# Evidence to the Committee on Advancing the Field of Forensic Pathology

Professor Lucy Easthope LLB MSc FHEA FRAI FEPS
Centre for Death and Society, University of Bath

Director, Whatever Next

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# Intro to me

- Coronial system
- Special interest in “state death” – many similarities – particularly in relation to areas like access to information, leverage of power, role of bereaved etc
- Highest year ever for deaths in custody:
- https://www.inquest.org.uk/iopc-stats-2023-4
- Neonatal deaths in custody
- Prison overcrowding and access to health - 175% capacity today at one HMP
- Private contractors
- Disease outbreaks

**In this country we do not give a death sentence, but for everyone who has taken their life in prison that is exactly what they got**

Mark Saunders, whose son Dean died in HMP & YOI Chelmsford in 2016

Source: Inquest.org.uk

# What does the coroner do?

An advocate for the dead to safeguard the living

# Becoming a coroner

- 5 years post legal qualification experience
- No more medical Coroners
- 92 Coroner areas – England and Wales
- Appointed and funded by Local Government
- **Independent** judicial officers
- Limited public presence
- Some disparity in decision making – improved by having a Chief Coroner
- Sudden, unexpected deaths, child deaths and crucially deaths in custody

# Not the same definition as the US

- Not a Pathologist or ME
- Coroner – more like a judge, can sit with a jury and sits in a court room
- We now have “medical examiners” which are also different

- Some very old law!
- Treasure

# Sample court

# Chief Coroner

- Provide support, leadership and guidance for coroners;
- Set national standards for coroners; **GUIDANCE NOTES**
- Develop training for coroners and their staff;
- Approve coroner appointments;
- Keep a register of coroner investigations lasting more than 12 months;
- Oversea transfer of cases between coroners;
- Monitor investigations of military deaths overseas;
- Provide annual report to the Lord Chancellor
- Meets with the Chief Inspector of Prisons

# Hierarchy of coroners

- Senior Coroners
- Area Coroners
- Assistant Coroners

# Subjectivity

- *"That necessarily imports a subjective element – the coroner's opinion – into the process. In the recent case of Dillon v HM Assistant Coroner for Rutland and North Leicestershire, the High Court stated that:*

- *"The coroner must act rationally in coming to the opinion held, but different coroners could reasonably come to opposite opinions on the same facts without either being wrong to do so. In other words, there is no single, objectively correct answer to the question raised by the second criterion in any particular case."*

- *It follows that the statutory duty to make a prevention of future deaths report may arise in one case and yet not do so in another, even where the underlying facts are completely indistinguishable"*

- https://www.judiciary.uk/speech-by-the-chief-coroner-death-in-custody-symposium/#:~:text="A%20senior%20coroner%20who%20is,or%20otherwise%20in%20state%20detention."

# Legal Framework

- The Coroners and Justice Act 2009

  = CJA
- The Coroners (Investigations) Regulations 2013

  = Regs
- The Coroners (Inquests) Rules 2013

  = Rules
- The Coroners Allowances, Fees and Expenses Regulations 2013

  = FREGS

# Coroner's and Justice Act 2009

- The Act was implemented on the 25/07/13
- The aim of the reform was to put bereaved people at the heart of the investigation
- The Chief Coroner and his office were create to provide governance to the service
- The concept of the coroner's investigation was created which would include an inquest unless discontinuance applied

# Some facts

- 500,000 deaths in England & Wales
- 220,000 referred to coroners (45%) of which:
  - 36% subject to post-mortem
  - 15% inquests
- Amongst those inquests would be:
  - traffic fatalities
  - homicides (75% male)
  - suicides (78% male)
  - many thousands of medical incidents

# Duty to investigate

- A coroner has a duty under s1 of the 2009 Act to investigate a death if:

1. the coroner is made aware that the body is within that coroner's area (s1(1)), and
2. the coroner has reason to suspect that –

a. the deceased died a violent or unnatural death,

b. the cause of the death is unknown, or

**c. the deceased died while in custody or state detention (s1(2))**

# Coroner's Powers and Actions on Receipt of a Reportable Death

The Coroner has several courses of action:

1) To certify death as being due to Natural Causes without obtaining a post-mortem report (Part A)

2) To certify death as being due to Natural Causes after obtaining a post-mortem report that confirms it (Pink Form 100B procedure)

3) Open an investigation (certificate of fact of death and release the body)

4) To open an Inquest (with or without PM)

# Enquiries

- Do we have a proper and accurate identification?
- Is there any prospect of foul play?
- What are the **full** circumstances surrounding the death?
- Who is the **appropriate** family member to deal with?
- What is the relevant medical history?
- Can a treating doctor **reasonably** sign a certificate for a natural death?
- If so, what do the family think of this? What can they add?

# Post Mortem Examinations

- Invasive

  - Free of charge – paid for by the state
  - Cannot ever go back to pre-dissection

# PMCT as an adjunct

- Chief Coroner encourages its availability and use
- More detailed autopsy without need to dissect
- Enhanced Coroners enquiry
- Enhanced Police investigations
- Application to mass fatalities
- Enhanced Court presentations
- Have forever – go back to / get a second opinion

**Pathologist** gives the cause of death and provides the report

# Issues

- More expensive than fee charged to coroners for an invasive autopsy
- Families may have to pay
- Not available in all parts of the country (but gradually becoming more so)

# Article 8 ECHR

- Right of the deceased's family to respect for private and family life
- Includes respect for the body
- Religious and cultural
- The right thing
- Awareness could increase demand

# Art 9 ECHR

**Freedom of thought, conscience and religion**

1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to manifest his religion or belief, in worship, teaching, practice and observance.

# Next steps

- The results of the PMs are brought to the Coroner
- If the cause is Natural Coroner issues a Part B and discontinue the investigation
- If Histology or Toxicology has been requested the Coroner will open an investigation

# Open an investigation

- “Certificate of fact of death”
- Release the body

# Pre Inquest Review

- Published
- In Court
- Disclosure to prepare
- Agenda:
    - is Article 2 engaged
    - Scope of the inquest
    - Properly Interested Persons
    - Need for a jury
    - Witnesses
    - Expert
    -Disclosure
    - Bundles

# Properly Interested Persons

S47 Expanded list including:-

- Spouse, civil partner, parent, child, brother, sister, grandparent, grandchild, nephew, niece, stepfather, stepmother, half brother, half sister, LAT
- Personal Representative of the deceased
- Medical Examiner
- Beneficiary under a policy of insurance
- Person whose act/omission may have contributed to the death
- Trade Union where work death or from prescribed disease
- IPCC
- Appointed Government department
- Another person with **sufficient interest**

# Inquest - General

An Inquest is a part of the investigation and is required where death is: -

- Unnatural or violent
- In custody or state detention

r5(1) An Inquest must be open as soon as reasonably practicable

r5(2) Coroner must where possible set dates for subsequent hearings

r11 must have all hearings in public including the opening (unless matters of national security dictate otherwise)

r25 all hearings must be recorded (£5 for a CD)

r8 must complete all Inquests in 6 months, or as soon as reasonably practicable.

# Inquest – 1 Year Old Cases

s16(1) Duty to notify the Chief Coroner of all investigations not discontinued or completed within 1 year

s16(2) 12 months from the day on which the Coroner was made aware of the death

Must also notify the Chief Coroner of the date the investigation is completed

# The Inquest

- s5 CJA 2009 :

  The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely –

  Who the deceased was;
  How, when and where the deceased came by his death;

- Tell me about ……

# Inquest – Evidence

r17 evidence by video link

r18 evidence behind a screen

r19 examination of witnesses

r20 order of examination

r22 self incrimination

r23 written evidence

# Conclusion

s10 CJA 2009

No conclusion shall be framed in such a way as to appear to determine any question of –

a) criminal liability on the part of named person, or

b) civil liability

# Example conclusions

- Unlawfully killed https://www.judiciary.uk/guidance-and-resources/chief-coroners-law-sheet-no-1/
- Suicide
- Industrial
- Related to trauma (old or new, surgery is trauma)
- Poisoning (medicines)
- Accident
- Road traffic collision
- Alcohol/Drug related
- Neglect
- Narrative conclusion

# Verdicts

- Possible outcomes include: natural causes; accident; suicide; unlawful or lawful killing; industrial disease and open verdicts (where there is insufficient evidence for any other verdict). Sometimes a coroner uses a longer sentence describing the circumstances of the death, which is called a narrative verdict.

# Jury Inquests

- An inquest **must** be held **without** a jury unless section 7(1) applies.

# Section 7

A jury must be summoned where the deceased:

1. died while in custody or state detention **and** the death was violent, unnatural of cause unknown;
2. died as a result of an act or omission of a police officer or member of a service police force during their duties;
3. died by an accident, poisoning or disease which must be reported to a government department or inspector

# Jurors

- 7 – 11
- Electoral register
- Summons
- Coroner directs on the law and summarises the evidence
- Unanimous and majority conclusions

# What should the inquest achieve?

- independent scrutiny of events surrounding a violent death
- establish the facts
- allow properly interested persons an opportunity to question witnesses
- draw attention to circumstances which might lead to further deaths

# Prevention of Future Deaths

- Sch7 para 5 Reg 28 and 29 Actions to prevent other deaths
- Prevent further death report
- Central to the whole process
- Coroner now has a duty to report
- Copies now sent to the Chief Coroner’s Office

# When are reports made?

- If during the investigation or inquest something is revealed that “gives rise to a concern”
- In the Coroner’s opinion action should be taken to prevent those circumstances
- Not restricted to matters causative of the death in question
- A PFD is a recommendation that action should be taken but NOT what that action should be.

# PFDs and deaths in custody

- “A significant proportion of PFD reports issued over the past year raise concerns in relation to inadequate staffing levels within prisons and the impact that has on the safety of prisoners. Insufficient staffing has a range of dangerous effects”
- https://www.hilldickinson.com/insights/articles/thematic-review-recent-prevention-future-deaths-pfd-reports#:~:text=Deaths%20in%20prison%20custody,a%20range%20of%20dangerous%20effects.

# Statistics for custody, prisons and migration detention

www.inquest.org.uk

# In practice:

When a call comes in about a detained person…

1. Can a prison doctor give a cause such as cancer they were treating them for?
2. Family requests. Care issues? Documentary evidence
3. PM? Type of PM? Tox?
4. **Inquest – S9C**
5. Unnatural? **Jury inquest with a full PM**
6. Verdict
7. PFD
8. In extremis e.g. Covid https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-34-covid-19/#:~:text=COVID%2D19%20deaths%20in%20state%20detention&text=Section%201%20CJA%202009%20requires,death%20is%20from%20natural%20causes.

*Coronial overreach – burial and ashes*

# Recent Case Studies:

- https://www.inquest.org.uk/haydar-jefferies-inquest

- https://www.inquest.org.uk/jessica-powell-inquest-concludes

# Independent Advisory Panel – deaths in custody

- https://iapdeathsincustody.independent.gov.uk

- Advises government on how to prevent further deaths in custody – see attachment for latest evidence

# Prisons and Probation Ombudsman

“We investigate deaths in custody, and complaints from people who are in custody or under community supervision. We are a completely independent organisation”

https://ppo.gov.uk/investigating-deaths/

# Some key further resources

- Inquest

https://www.inquest.org.uk

- Coronial service description:

https://www.judiciary.uk/courts-and-tribunals/coroners-courts/coroners/#:~:text=Coroners%20are%20independent%20judicial%20office,each%20jurisdiction%20is%20locally%20funded.

- ”Dead bodies and the law”

https://deadbodiesandthelaw.wordpress.com

# “Deaths in Prison: A national scandal”

- https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b

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Director@whatevernext.org.uk

@lucygobag – X

@lucygobag.bsky.social

@WhenTheDustSettlesLucy - INSTA

**www.whatevernext.info**